Minutes of the meeting of the Board of Directors of the Cook County Health and Hospitals System held Thursday, November 19, 2009 at the hour of 7:30 A.M. at John H. Stroger, Jr. Hospital of Cook County, 1901 W. Harrison Street, in the fifth floor conference room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Batts called the meeting to order at approximately 7:30 A.M.

Present: Chairman Warren L. Batts, Vice Chairman Jorge Ramirez and Directors David A. Ansell, MD, MPH; Hon. Jerry Butler; David Carvalho; Quin R. Golden; RSM; Luis Muñoz, MD, MPH; Heather E. O'Donnell, JD, LLM; and Andrea Zopp (9)

Absent: Directors Benn Greenspan, PhD, MPH, FACHE and Sister Sheila Lyne (2)

Additional attendees and/or presenters were:

John Abendshien	Jeanene Johnson	Deborah Santana
Michael Ayres	Randolph Johnston	Thomas Schroeder
Robert Cohen, MD	Stephen Martin, PhD, MPH	Deborah Tate
William T. Foley	Suja Mathew, MD	Anthony J. Tedeschi, MD, MPH, MBA
Commissioner Bridget Gainer	Elizabeth Reidy	Ed Wenske

II. Public Speakers

Chairman Batts asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speakers:

1. George Blakemore	Concerned Citizen
2. Carol O'Neil	Dietitian III, Oak Forest Hospital of Cook County and Chief Union Steward, SEIU Local 73 (written testimony also provided*)

*Note: after Ms. O'Neil presented her testimony, Director Carvalho requested that the Board receive feedback from the administration regarding Ms. O'Neil's comments, which referenced the System's data on rebalancing estimates for Oak Forest Hospital of Cook County. William T. Foley, System Chief Executive Officer, noted that the final report and executive summary on the performance improvement assessment would be provided later on at this meeting; a large part of that report dealt with labor productivity and led to the background justification for the reduction in force. Additionally, he stated that Dr. Anthony Tedeschi, System Interim Chief Operating Officer, would reconcile the information provided in Ms. O'Neil's testimony with the System's data and report back to the Board.

III. Report from Chairman of the Board

Meeting with medical staff of John H. Stroger, Jr. Hospital of Cook County

Chairman Batts reported that he recently met and spoke with the medical staff at John H. Stroger, Jr. Hospital of Cook County. At this meeting, they discussed the subject of the mock Joint Commission survey; he noted the importance of this matter and the ongoing efforts relating to it.

III. Report from Chairman of the Board (continued)

Update on CCHHS Smoke-Free Campuses

Chairman Batts introduced Dr. Robert Cohen, from the Department of Pulmonary and Critical Care Medicine, who reported that as of November 19, 2009, smoking will be prohibited on all System properties. Dr. Cohen thanked all of those involved in the implementation of this policy, including Lucio Guerrero, System Director of Public Relations and Community Affairs, and Kristina Photakis, from Mr. Foley's office.

Board Education – Report on Internal Medicine Residency Training Program, John H. Stroger, Jr. Hospital of Cook County

Chairman Batts noted that, starting with this meeting and going forward, the Board will dedicate time for Board education. For this meeting's Board education presentation, Dr. Suja Mathew, Program Director for the Department of Medicine, presented a report on the Internal Medicine Residency Training Program (Attachment #1).

Discussion of Academic Relationships

The Board briefly discussed the subject of System relationships with other private hospitals. Director Carvalho noted that, in the past, the County's decision to enter into these types of relationships has been based upon whether it is in the County's best interests to do so. Director Muñoz stated that he is interested in reviewing the relationship with Rush. Mr. Foley stated that currently, there is a group that is looking at all of the System's academic relationships; additionally, they will be looking at all of these relationships as the System advances to the implementation phase for performance improvement.

IV. Report from Chief Executive Officer

A. Strategic planning update

Mr. Foley provided an update on strategic planning efforts. He stated that, according to the original schedule, the plan was to be presented and approved by the Board this month. However, they want to take the time to further analyze the issues and the input received. He noted that he believes that the basic essence of the plan is solid; particularly in looking at how access can be better addressed. He added that the issue of access is not solely related to geography; he believes that in order to address the issue of access, this also includes fixing what is broken within the System, whether it is related to scheduling, processes, etc. Additionally, Mr. Foley stated that he believes that the concept of focusing on comprehensive outpatient services by transitioning to the proposed regional healthcare centers, strategically located throughout the County (previously referred to as "hubs"), is the right thing to do.

John Abendshien, of Integrated Clinical Services, Inc., provided an update (Attachment #2) of the work in progress relating to the strategic plan. He stated that they have taken the work plan and looked at some specific steps that need to be taken between now and the February time period in order to bring the plan to completion, and to drill-down in some of the specific areas where there have been questions, to ensure that there is analytic support for the direction. He added that there are some areas that, under any scenario, management needs to move ahead in terms of implementing some of the operational initiatives. He referenced changes that have been made to the strategic initiative framework, and noted that one of the changes is to revise the nomenclature of the concept previously referred to as "hubs"; these are now generically described as "regional comprehensive outpatient delivery sites".

Mr. Abendshien proceeded with the update. The Board reviewed and discussed the information.

IV. Report from Chief Executive Officer

A. Strategic planning update (continued)

Extensive discussion took place on the following subjects: previous directions discussed and affirmed at the Board's October 7th retreat, specifically with regard to service line development initiatives; the financial plan for the strategic plan; and potential budgetary ramifications relating to the possibility that the Cook County Board will vote to roll-back the sales tax at their upcoming meeting.

During the discussion on maximizing the System's income, Mr. Foley stated that MedAssets is currently working on this; additionally, this information is incorporated into the budget, along with the opportunities identified in the performance improvement assessment. Director Muñoz requested a report on how this information is trending, in order to get a sense of whether there can be additional improvement and how additional opportunities can be found.

Also addressed during the discussion on the System's income was the issue of funding inequities relating to the existing financial structure. Director Carvalho noted that in 2009, the System successfully worked to bring in hundreds of millions in additional revenue. However, due to the financial structure in place with the County, the System did not receive credit for securing this additional revenue. Michael Ayres, System Chief Financial Officer, provided additional information on the subject, and added that this issue stems from the fact that this is an appropriations-controlled budget, not a "bottom-line" budget.

Director Ansell recommended that the issue of financial restructuring be remanded to the Finance Committee, so that a decision can be made on whether the System Board should commission a report on System's financial structure, standing separately from the strategic plan. Director Muñoz noted that the Audit and Compliance Committee should be involved in this discussion, as it involves historical funding issues. Director Zopp stated that although this is a critical piece to the strategic plan, she felt that there shouldn't be a separate commission on the financing; she felt that this could complicate matters. In response to the comments, Mr. Foley recommended that they include financial restructuring as the 6th core goal in the strategic plan.

Director Ansell, seconded by Director Golden, moved to direct the Finance Committee and Audit and Compliance Committee to conduct in-depth discussions and present recommendations on how to proceed with structural changes to the existing funding structure.

Director Zopp expressed concerns, stating that the System must first have their own vision of what the financing structure ought to be; she believed that the Board should review the financing options, then decide the direction, and move on to the processes of how to do it.

Director Ansell explained the reasons for his recommendation and motion. He stated that he prefers that issues are vetted through the committee structure, to allow for a broader discussion. Secondly, in the strategic plan, there are long-term and a short-term recommendations; there are actions that need to take place right away, including this issue. He added that this issue is not new; many Directors are very familiar with the issue and have a great deal of expertise on the subject. He stated that he prefers that the Board deal with it directly, rather than have Mr. Abendshien's group include it as part of their efforts. Additionally, he noted that there could be a lot of external support, including those who were previously involved in the Blue Ribbon Committee, who could be useful in the review of this subject.

IV. Report from Chief Executive Officer

A. Strategic planning update (continued)

On the motion, Chairman Batts called for a vote. A vote was taken, however, prior to Chairman Batts' declaration of the outcome of the vote, the Board returned to discussion of the matter, thereby leaving the motion pending.

Director Carvalho requested clarification on the motion, and noted that at the next Finance Committee meeting, they have requested and are expecting to receive the financial aspects of the plan. He asked whether the motion that was intended was to ask the Finance Committee and Audit and Compliance Committee to think about what structural changes or strategies they would recommend to be able to implement the strategic plan.

Director Zopp, seconded by Director Butler, moved to amend the motion, to direct the Finance Committee and Audit and Compliance Committee to conduct in-depth discussions and present recommendations on the financing plan. On the motion, as amended, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

B. Update on H1N1 efforts

Dr. Stephen Martin, Chief Operating Officer of the Cook County Department of Public Health, presented an update on H1N1 efforts. He stated that as of November 7th, it was the seventh straight week in which influenza activity has increased. The activity level for this week in suburban Cook County is 4% higher than the previous week.

Dr. Martin provided additional information on the number of vaccines received and administered, and provided an update on further activity planned for the distribution and administration of the vaccine. He stated that as of November 14th, the System has administered 8,552 doses of the vaccine and has received 16,526 doses of the vaccine from the City of Chicago's Department of Public Health and the Cook County Department of Public Health. As of November 16th, the Cook County Department of Public Health received 184,500 doses of the vaccine in six presentation types. As of November 30th, the Health Department has vaccinated 30,000 school children, has distributed over 19,100 doses to hospitals in the System, and has loaned 1,600 doses to municipal certified health departments. To date, they have distributed, administered, or loaned 57,550 doses.

In response to Director Muñoz' questions regarding whether the influenza activity is higher than in previous years, Dr. Martin responded affirmatively. Additionally, Dr. Martin noted that they are not seeing good vaccination rates among the African-American community; therefore, they are re-aligning their outreach strategies in response to this issue.

C. Introduction of Thomas Schroeder, Director of Internal Audit

Mr. Foley introduced and welcomed the new System Director of Internal Audit, Thomas Schroeder.

V. Board Report

A. Minutes of the Board of Directors Meeting, November 5, 2009

Director Ansell, seconded by Director Butler, moved the approval of the minutes of the Board of Directors Meeting of November 5, 2009. THE MOTION CARRIED UNANIMOUSLY.

VI. Recommendations, Discussion/Information Item

A. Final Report and Executive Summary – Performance Improvement Assessment

Ed Wenske, of Navigant Consulting, and Jeanene Johnson, Director of the Office of Performance Improvement, presented the Final Report and Executive Summary of the Performance Improvement Assessment (Attachment #3).

The Board reviewed and discussed the information. Extensive discussions took place on the subjects of physician alignment and productivity, and specific issues relating to Cermak Health Services.

Mr. Foley noted that some of the opportunities identified in the assessment are already being addressed. He stated that the next step is for the Finance and Human Resources Committees to review and make recommendations on the draft Request for Proposals (RFP) for outside help with limited implementation.

VII. Action Items

A. Any items listed under Sections V, VI and VIII

VIII. Closed Session Discussion/Information Item

A. Report on performance pertinent to accreditation standards for John H. Stroger, Jr. Hospital of Cook County

This item was withdrawn. Mr. Foley noted that he expects that the item will be on the next agenda, and will include information on the work plan that is being assembled in relation to the subject.

IX. Adjourn

Director Ansell, seconded by Director O'Donnell, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY AND THE MEETING ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXX
Warren L. Batts, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

Internal Medicine Residency Training Program, John H. Stroger Jr. Hospital of Cook County
Presented to the Board of Directors of the Cook County Health and Hospitals System
November 19, 2009
Suja Mathew, M.D., Program Director, Department of Medicine

The Internal Medicine Residency Program is a well -developed, well- established clinical training program with significant laurels.

- The admissions process is highly competitive and selective. Less than 1% of applicants are selected for entry. Applicants report interest in our program based on the following: the opportunity to actively participate in the care of patients with complex pathology; and the distinct, world-renowned practice of evidence-based clinical reasoning on our Medicine services.
- The Accreditation Council of Graduate Medical Education has given the Stroger Hospital Internal Medicine Residency Program full accreditation for the maximum time period of 6 years.
- Approximately 50% of our graduates pursue fellowship training, and are placed in competitive fellowships in all the internal medicine core sub-specialties. The remainder continues the practice of general internal medicine, in both the hospital and ambulatory settings.
- Our three-year American Board of Internal Medicine certifying exam passage rate meets or exceeds the rates of the country's most prestigious academic medical centers.

The Internal Medicine Residency Program is an integral player in the Department of Medicine's clinical mission.

- Residents participate in the care of every patient admitted to the Department of Medicine clinical services. They help to staff 12 general medicine ward services, 4 HIV inpatient services, the MICU, the CCU, and the Short-stay unit; help provide consultative services to every department in the hospital, in all medicine sub-specialty areas; and provide staffing to the emergency room. They spend one half-day per week as outpatient primary care providers in the General Medicine Clinic, providing continuity of care to patients discharged from the Medicine ward services.
- Unique aspects of our training program facilitate the integration of clinical care and education, including the format of teaching activities such as morning report.
- The housestaff play an important role in the Department's quality improvement activities. Examples include 1) Hand-offs of care are standardized on the Medicine inpatient services, in accordance with NPSG 2; 2) Residents are first and immediate responders to calls for an Early Response, in accordance with NPSG 16; 3) Housestaff provide discharge summaries to patients at the time of discharge, including medication reconciliation, in accordance with NPSG 8.
- The ability to recruit and retain high quality attending physicians in the Department of Medicine is improved by the residency program.

ATTACHMENT #2

Integrated Clinical Solutions, Inc.

Cook County Health and Hospitals System

STRATEGIC PLAN—Process for:
-Plan Completion
-Moving Forward with Critical Priorities

November 19, 2009

Envisioning a Successful Future State

Key Challenges Today

- Significant access barriers
- Limited primary & specialty care resource base
- Facility locations/configuration not conducive to effective System operations
- Fragmented care delivery
- Low patient/caregiver satisfaction
- Staff morale low; recruitment & retention difficult

How are we going to get there?

CCHHS Future State

- Geographically distributed services are highly accessible
- Primary care and specialized needs are met through a combination of County resources and partnerships
- The “right services in the right places”
- Services are patient-centered and fully integrated System-wide
- Patient and caregiver satisfaction levels are in the top quartile
- Caregivers are attracted to System; evolving leadership in place

Strategic Plan: VISION 2012 (revised draft 11/16/09)

Mission

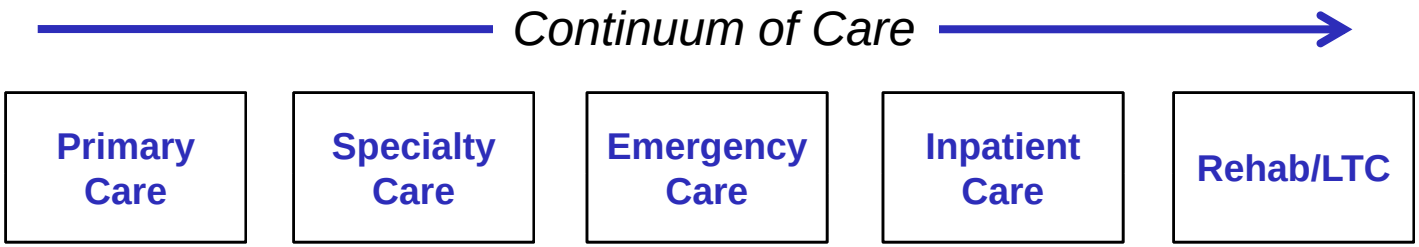
To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well being of the people of Cook County.

Vision 2012

In support of its public health mission, CCHHS will be recognized locally, regionally, and nationally —and by patients and employees—as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally-responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County.

Core Goals	Strategic Initiatives
I. Access to Healthcare Services	• Eliminate System access barriers at all delivery sites. • Designate and develop 3-5 regional delivery sites for provision of comprehensive outpatient services. • Rebuild Fantus Clinic and expand parking capacity; evaluate optimal long-term development of Provident, Oak Forest, and ACHN sites.
II. Quality, Service Excellence & Cultural Competence	• Develop an integrated, System-wide approach and supportive infra-structure for patient-centered care coordination. • Implement a System-wide program of continuous process improvement: patient care quality, safety, and outcomes. • Develop a comprehensive program to instill cultural competency.
III. Service Line Strength	• Develop/strengthen clinical service lines in needs-based areas such as cancer, cardiac, diabetes, emergency/trauma, burn, HIV/AIDS, rehabilitation and surgery; evaluate optimal development of OB, pediatrics, neonatal care. • Pursue mutually beneficial partnerships with community providers. • Assure the provision of the Ten Essentials of Public Health.
IV. Staff Development	• Implement a full range of initiatives to improve caregiver/employee satisfaction. • Focus on effective recruiting and retention processes. • Develop a robust program for in-service education and professional skill building.
V. Leadership & Stewardship	• Foster leadership development and succession planning. • Develop long-term financial plans and sustaining funding. • Hold Board and management leadership accountable to agreed-upon performance targets.

Key Questions—Confirming Strategic Direction



Current State:

- What amount of healthcare does the system currently provide?
- What amount can be provided in the near future given a "momentum" scenario and what changes are necessary to support material increases?
- What are the limitations of the delivery platform from a cost, quality, and access perspective?

Future State:

- What should be the future role and focus for primary care, specialty care, and inpatient care development?
- What will be the impact on the volume and effectiveness of health care services if the current platform is reconfigured as recommended in the Strategic Plan?

Next Steps (Nov. – Feb.)

1. **"Make the case" for recommended delivery platform—develop analytics and specifications that:**
   - → Define desired objectives for primary and specialty care and planning to determine optimal distribution of services within the System.
   - → Determine optimal geographic and operational configuration of regional comprehensive outpatient services sites and ACHN centers, considering patient demographics and concentration of existing FQHCs.
   - → Evaluate viability of Oak Forest and Provident hospitals as acute care inpatient facilities based on need and cost/benefit; identify options for System reallocation of resources (including possible reconfiguration of Oak Forest and Provident sites).
   - → Identify opportunities/options for partnerships with other provider organizations.
   - → Determine resources required to support recommended delivery platform versus the current configuration.
   - → Determine impacts and cost/benefits of proposed System redirection on potential volumes of patients served, access, types and levels of services provided, continuity of care, quality of care.

Next Steps (Nov. – Feb.)

2. **As an essential part of the case, define regional comprehensive outpatient services model:**
   - → Conduct benchmark research on similar models in other settings.
   - → Specify key clinical components of regional model.
   - → Design operational model, including linkage with other CCHHS clinics and partners.
   - → Estimate potential volumes and resource requirements.

3. **Proceed with service line development initiatives:**
   - → Confirm priorities and develop template for service line development.
   - → Initiate “fast-track” development of high-priority service lines: Trauma/Emergency Services, Women & Children and Surgery.
   - → Develop timelines for other service line initiatives.

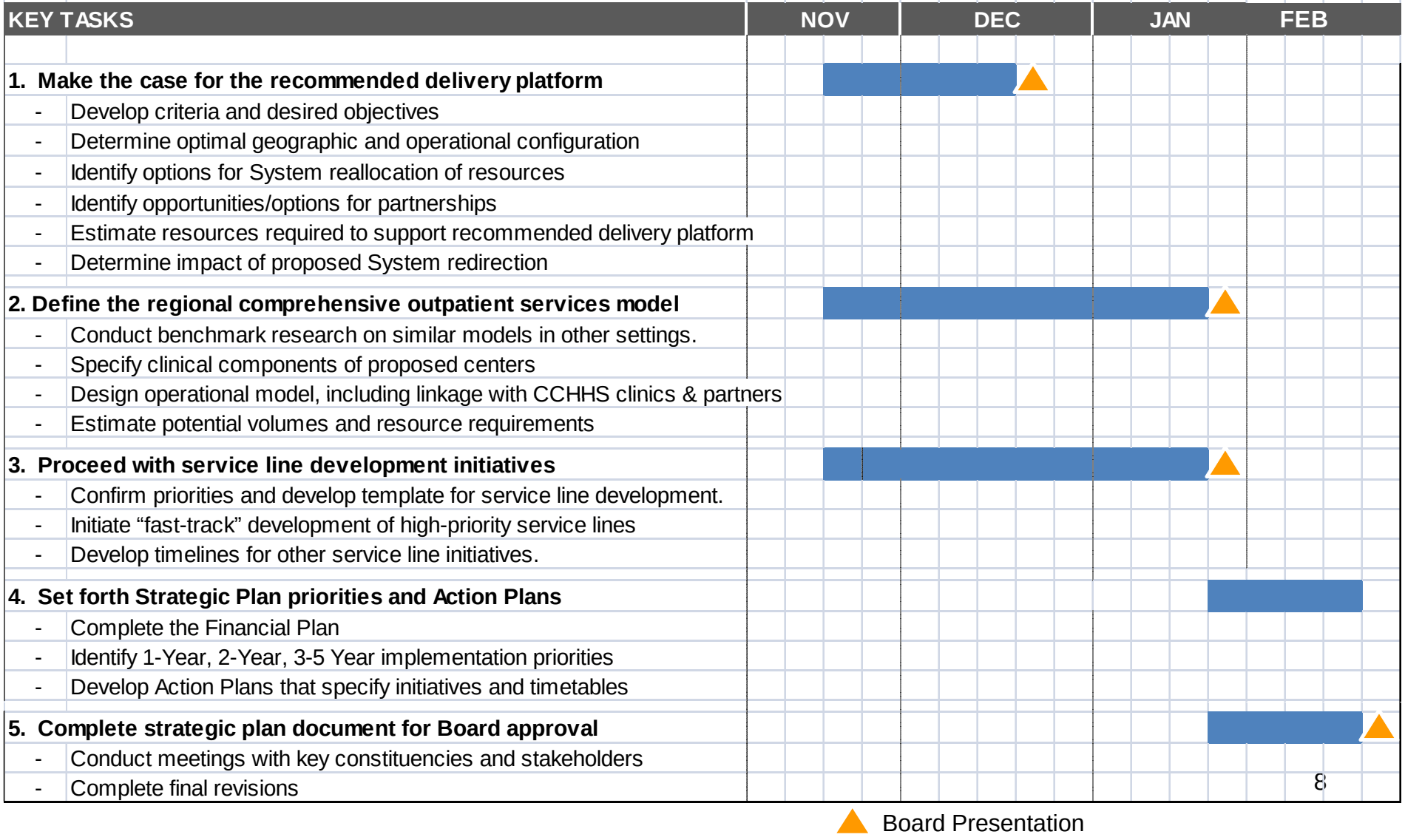
Next Steps (Nov. – Feb.)

4. **Set forth Strategic Plan priorities and Action Plans:**
   - → Based on criteria related to strategic importance, relative impact, and feasibility, categorize strategic initiatives into Immediate, 1-Year, 2-Year, and 3-5-Year implementation priorities.
   - → Develop Action Plans that specify initiatives and timetables.

5. **Complete Strategic Plan document for Board approval:**
   - → Conduct meetings with key constituencies and stakeholders.
   - → Complete final revisions.

Workplan and Timetable

CCHHS Strategic Planning Tasks/Timeline



ATTACHMENT #3

Cook County Health and Hospitals System
Performance Improvement Project

Executive Summary of Findings and Next Steps

To

Board of Directors

November 19, 2009

Prepared

By

Navigant Consulting Inc.

NAVIGANT CONSULTING

OVERVIEW

The Cook County Hospitals and Health System ("CCHHS") determined the need for additional external expertise to augment and assist management in assessing priority areas for improvement, develop the necessary plans to carryout turnaround efforts, and implement these plans in the achievement of the stated operational improvements. CCHHS chose Navigant Consulting, Inc., a publicly traded organization headquartered in Chicago, IL. Navigant has a very large healthcare consulting practice with over 400 professionals with the requisite expertise and track record in assisting healthcare organizations with similar turnaround projects.

I. ENTITIES INLCUDED WITHIN REVIEW

The scope of services outlined in the engagement included CCHHS entities of:

Phase I:

- John H. Stroger, Jr. Hospital ("JSH")
- Oak Forest Hospital ("OFH")
- Provident Hospital ("PHCC")
- Department of Public Health ("DPH") [Scope to be further defined prior to agreement]
- Ambulatory and Community Health Network ("ACHN")
- Health System corporate services

Phase II:

- Cermak

II. AREAS OF FOCUS:

The focus was on four primary areas organized as follows:

1. Physician Alignment
2. Workforce Efficiency/Operations
3. Supply Chain
4. Clinical Resource Management

SCOPE OF WORK

I. PHYSICIAN ALIGNMENT

Physician alignment focused on areas where rapid revenue enhancement and expense reduction opportunities would be generated. These areas included:

Financial	Operational
• Physician compensation and productivity • Contracting/ compensation	• Capacity Management • Demand Management • Access Management • Flow Management

II. WORKFORKFORCE EFFICIENCY

Workforce efficiency focused on:

Area of Transformation	Performance Variables and Standards
Structure	» Mission and service alignment » Number of management levels by Department » Span of control targets
Resource Usage	» Comparison vs. peer "best practices" » FTEs and work hours (paid/worked) » Overtime, agency and sitters » Salary expense/rates
Human Resource Management	» Union contract requirements » Policies and procedures » Compensation structure » Outsourcing arrangements » Recruitment, retention & workforce availability » Ability to adapt to surge
Process Review	» Patient throughput and capacity management » Patient care delivery processes » Ancillary/support processes » Utilization & care management » Technology enabled process efficiencies
Productivity Systems	» Productivity tools/metrics » Resource usage against productivity standards » Strengths and weaknesses of tools
Culture and Change Management	» Constituent feedback on structure, service focus and resource utilization » Impediments, constraints and risks in force reduction » Union related processes » County requirements and processes

III. CLINICAL RESOURCE MANAGEMENT:

The Clinical Resource Management assessment was designed to help CCHHS improve clinical and operational practices and patterns while maintaining and improving, where possible, patient care.

This initiative required focused reviews in several areas:

IV. SUPPLY CHAIN:

The approach to Supply Chain improvement was developed around the principles of client interaction, knowledge transfer, and sustained improvement. This process involved:

- Benchmarking using NCI database for comparative hospitals
- Conducting a second level of analysis using product and payment reports to identify specific pricing and utilization opportunities to develop a portfolio of opportunities and savings potential

Physician Preference Items	• Orthopedic Implants • Spinal Implants • Pacemakers & Defibrillators • Stents
Purchased Services	• Agency/Temp Services • Outsourced Support Services • Biomedical Engineering • Imaging Services
Clinical Commodity Items	• Suture • Blood
Pharmacy & Laboratory Items	• Wholesaler contracting • 340b Pricing • Drug Utilization Management

V. SCHEDULE:

Phase I

- Steering Committee #1 – July 14, 2009
- Steering Committee #2 – July 23, 2009
- Steering Committee #3 – August 6, 2009
- Steering Committee #4 – August 13, 2009
- Steering Committee #5 – August 20, 2009
- Steering Committee #6 – August 25, 2009
- Steering Committee #7 – September 30, 2009

Phase II – Cermak

- Steering Committee #8 – November 3, 2009

SUMMARY OF OPPORTUNITY – PHASE I

I. OVERALL

There is an overall saving opportunity of between $65 – $72 Million for Phase One effort.

$31.8M	Labor Productivity	• Achievement of NCI Identified Productivity Standards • Overtime Hours Phase I improvement
$3M	Care Management	• Conservative assumption of 5% improvement in all admission LOS improvement
$17-23M	Supply Chain	• Pricing • Utilization
$13.8M	Physician & Mid-Level Productivity	• Conservative estimate. Significant in depth analysis and restructuring needed before total dollar opportunity can be finalized

Total Opportunity: $65 – 72 M

II. LABOR – OAK FOREST HOSPITAL

Oak Forest Hospital					
CATEGORY	Actual WORKED FTEs	IDENTIFIED FTE OPPORTUNITIES	FTE ADDITIONS	FTE @ NCI RECOMMENDED LEVEL	TOTAL REDUCTION %
Nursing Services	208.6	60.9	0.00	147.7	29.2%
Clinical Services	115.2	30.3	0.00	84.9	26.3%
Emergency Services	39.6	5.2	0.00	34.4	13.1%
Interventional Services	10.6	4.5	0.00	6.1	42.5%
Finance	70.2	2.3	0.00	67.9	3.3%
Support Services	264.1	92.3	0.00	171.8	34.9%
Administration	30.7	0.0	0.00	30.7	0.0%
IT/Telecom	6.9	0.0	0.00	6.9	0.0%
Clinics	0.0	0.0	0.00	0.0	0.0%
Programs and Other	0.1	0.0	0.00	0.1	0.0%
Opportunity - Worked FTEs	**746.0**	**195.5**	**0.0**	**550.5**	**26.2%**
Opportunity - Paid FTEs	**894.8**	**234.5**	**0.0**	**660.3**	
Total Opportunity - Net Paid FTEs	**894.8**	**234.5**			
Annualized Dollar Opportunity*		**$11,362,803**			

*** Average Salary & Benefits of $48,460 used to calculate Annualized Dollar Opportunity**

III. LABOR – PROVIDENT HOSPITAL

Provident Hospital					
CATEGORY	Actual WORKED FTEs	IDENTIFIED FTE OPPORTUNITIES	FTE ADDITIONS	FTE @ NCI RECOMMENDED LEVEL	TOTAL REDUCTION %
Nursing Services	156.2	22.8	0.00	133.5	14.6%
Clinical Services	68.9	3.0	0.00	65.9	4.3%
Emergency Services	58.0	0.0	(5.30)	63.3	-9.1%
Interventional Services	24.4	14.0	0.00	10.4	57.3%
Finance	60.1	0.0	(1.87)	62.0	-3.1%
Support Services	67.8	2.6	0.00	65.3	3.8%
Administration	22.5	0.0	0.00	22.5	0.0%
IT/Telecom	9.0	1.4	0.00	7.6	15.6%
Clinics	0.0	0.0	0.00	0.0	0.0%
Programs and Other	0.0	0.0	0.00	0.0	0.0%
Opportunity - Worked FTEs	**466.9**	**43.7**	**(7.17)**	**430.4**	**7.8%**
Opportunity - Paid FTEs	**550.4**	**51.5**	**(8.45)**	**507.4**	
Total Opportunity - Net Paid FTEs	**550.4**	**43.0**			
Annualized Dollar Opportunity*		**$2,356,259**			

*** Average Salary & Benefits of $54,775 used to calculate Annualized Dollar Opportunity**

IV. LABOR – JOHN H. STROGER HOSPITAL

John H. Stroger Hospital					
CATEGORY	Actual WORKED FTEs	IDENTIFIED FTE OPPORTUNITIES	FTE ADDITIONS	FTE @ NCI RECOMMENDED LEVEL	TOTAL REDUCTION %
Nursing Services	719.3	98.6	0.0	620.7	13.7%
Clinical Services	563.6	42.3	0.0	521.4	7.5%
Emergency Services	207.3	19.5	(35.6)	223.3	-7.7%
Interventional Services	169.2	3.6	(11.9)	177.5	-4.9%
Finance	226.3	10.2	(14.1)	230.3	-1.8%
Support Services	471.1	35.2	0.0	435.9	7.5%
Administration	60.9	0.0	(1.3)	62.1	-2.1%
IT/Telecom	10.7	1.5	0.0	9.2	13.8%
Clinics	0.0	0.0	0.0	0.0	0.0%
Programs and Other	1.4	0.0	0.0	1.4	0.0%
Opportunity - Worked FTEs	**2,429.7**	**210.9**	**(62.9)**	**2,281.8**	**6.1%**
Opportunity - Paid FTEs	**2,871.8**	**249.2**	**(74.4)**	**2,697.0**	
Total Opportunity - Net Paid FTEs	**2,871.8**	**174.9**			
Annualized Dollar Opportunity*		**$14,844,442**			

*** Average Salary & Benefits of $84,894 used to calculate Annualized Dollar Opportunity**

V. LABOR – PREMIUM PAY

- CCHHS hospitals are well above the NCI overtime benchmark of 2% of total worked hours.
- NCI recommends Agency Hours at the benchmark of 1% of total worked hours, but there is not a comprehensive data source to track Agency hours, so the opportunity was unable to be assessed.

Entity	Indicator	2009 YTD	2008	NCI Preferred %	Phase I Reduction Target (decrease 2%)	Paid FTEs Converted from Premium	$ Savings at Phase I Target
Oak Forest	Overtime Hours as % of Worked Hours	4.47%	4.99%	2.00%	2.47%	8.0	$193,000
Provident		10.81%	11.46%	2.00%	8.81%	11.1	$303,000
Stroger		8.77%	9.09%	2.00%	6.77%	64.6	$2,743,000
					TOTAL PHASE I REDUCTION SAVINGS		$3,239,000

VI. PHYSICIAN SERVICES – PROVIDERS

NCI employs a mission-based management methodology with the acronym "CARTS" to analyze the multifaceted activity of an academic or teaching physician.

C	Clinical Practice Income	Medical Practice, Hospital clinics, other
A	Administrative Fees	Hospital, other
R	Research Grants	
T	Teaching → Graduate Medical Education (Hospital) → Undergraduate Medical Education (School of Medicine)	
S	Strategic Support → Clinical programs → Research activities → Core/mission-critical program operating at a deficit	Hospital, Philanthropy

The CARTS analysis consolidates the requirements of CCHHS for all missions.

- There are 106 FTE of excess providers.
- It is important to note that the clinical requirement has already been enhanced by 30% to account for inferior data quality.

		Required			
	Paid FTE	Clinical *(enhanced)*	Medical Admin	Teaching	Excess Providers
CCHHS Total	**592.1**	**382.0**	**26.2**	**77.9**	**106.0**
ACHN	56.1	51.7	3.2	-	**1.2**
Oak Forest	49.6	28.5	1.5	-	**19.6**
Provident	86.7	45.0	1.5	2.0	**38.2**
Stroger	399.7	256.8	20.0	75.9	**47.0**

The recommendation is to eliminate 85% of excess provider positions, or 90 FTEs, after all mission requirements have been satisfied.

Additional comments and recommendations include:

CCHHS does not currently have the ability to monitor individual physician productivity. • **It is paramount that this be fixed.**
Physician work expectations are not clearly delineated or matched with need: • Physicians self-report 48.5% of their time as "teaching", much greater than the need. • Clinical activity is a much smaller expectation than required.
Resolve Human Resource issues to align with expectations. • Delineate all expectations related to time and activity in each position description. • Expand the salary range for faculty and physicians to allow for market competitive rates. • Create ability to split 1.0 FTE positions into smaller increments.

VII. PHYSICIAN SERVICES – ACHN

Comments and recommendations relating to ACHN include:

The clinics **run at about 59% efficiency based on the NCI flow optimization model.**
There are **significant process issues** which inhibit effective staffing patterns and reduce the productivity of physicians.
The support staffing analysis indicates **significant variance between locations based on worked hours per visit**.
There is a need to enforce consistent use of established operating policies and procedures through aggressive training, competency validation and performance monitoring.
Establish definitive functional skill set and adjust staffing mix accordingly.

VIII. SUPPLY CHAIN

NCI Normalization demonstrated a high level savings opportunity of: $17M - $23M

PERFORMANCE INDICATORS - PERCENTILE RANKING			
	All CCHHS Hospitals		
Metric	Current Level	Low Target	High Target
Supply Expense % of Net Operating Expense	36.9%	22.4%	16.6%
Supply Expense % Net Revenue	63.3%	43.5%	34.3%
Supply Expense Per Adj Discharge	111.0%	81.6%	66.2%
Target Peer Group Ranking (percentile)	70.4%	49.2%	39.1%
Corresponding Savings		$ 17,316,081	$ 23,500,396

During the engagement, specific opportunities in the range of $11M - $15M were identified. Examples of these opportunities include:

CATEGORY	INITIATIVE	ANNUAL SPEND	LOW TARGET SAVINGS	HIGH TARGET SAVINGS
Pharmacy	Drug Utilization - Outpatient Formulary		$ 1,063,234	$ 1,500,000
	Drug purchase under 340B		$ 210,000	$ 1,000,000
	Revenue from Copay		$ 500,000	$ 1,000,000
Pharmacy Total			$ 1,773,234	$ 3,500,000
Lab	Insourcing of lab tests	$ 805,247	$ 219,523	$ 219,523
	Reference Lab pricing	$ 805,233	$ 184,256	$ 184,256
	Blood Bank	$ 3,200,000	$ 39,409	$ 78,755
Lab Total		$ 4,810,480	$ 443,188	$ 482,534
Non-Clinical	Biomedical Contracts	$ 6,445,428	$ 1,300,000	$ 1,700,000
	Contract Security	$ 984,911	$ 276,804	$ 511,293
	Medical Gases	$ 1,900,000	$ 133,888	$ 169,888
	Dietary Savings	$ 1,561,964	$ 121,429	$ 265,402
Non-Clinical Total		$ 10,892,303	$ 1,832,121	$ 2,646,583
Sub Total		**$ 28,472,752**	**$ 5,585,989**	**$ 8,952,119**

IX. CLINICAL RESOURCE MANAGEMENT

Key findings and recommendations include:

The current model for each of the facilities would be described as **a traditional Utilization Review and Discharge Planning approach** to case management.

Compliance/preventative measures, such as Medicare conditions for participation Recovery Audit Contractors focus areas, are limited.

Limited data available and no case management dashboard/report card exists to evaluate the impact of case management activities.

Develop written criteria to guide patient assignments based on changes in the patient condition that are consistent across similar levels-of-care.

Develop a CCHHS Nursing Services Quality Dashboard monitoring standardized key nursing sensitive metrics.

Additional resources are required to achieve effective staffing and impact average length of stay (ALOS) at each hospital.

Staffing	Payroll Spend 7/28/09	Proposed Paid FTEs	Net FTE Impact	Investment Dollars
PHASE I				
Stroger			1.0	
Oak Forest	10	7.2	(2.8)	
Provident	6	8.2	2.2	
Sub-Total Phase 1				**($30K)**
PHASE II				
Stroger			15.7	
Oak Forest	N/A	N/A		$0
Provident	N/A	N/A		$0
Sub-Total Phase 2				**$947K**
PHASE III				**TBD**
TOTAL				**$917K**

The additional expenditure of resources would be more than compensated by a favorable return on investment (ROI) in average length of stay.

Case Management All Hospitals

Staffing	Current All Payor ALOS	5% Improvement Opportunity	Total Day Opportunity	Financial Impact
Stroger	5.04	4.79	5908	$2.6M
Oak Forest	6.1	5.8	939	$0.4M
Provident	3.98	3.98	0	
TOTAL				**$3.0M**
ROI				**3 to 1**

Actual opportunity is likely much greater. At present, it is not possible to track unnecessary admissions, inaccurate coding of diagnosis, and other critical variables.

SUMMARY OF OPPORTUNITY – CERMAK

I. LABOR EFFECTIVENESS

There are modest opportunities for improvement in labor effectiveness in a number of departments at Cermak. These are offset by a need to add additional personnel in Mental Health.

Functional Area	Sum of Worked FTEs	Sum of Paid FTEs	Workload Unit Measure	Workload Unit	Productivity Definition	Productivity Benchmark	Actual Productivity	Worked FTE Opportunity	Worked FTE Additions	Net Worked FTE Opportunity	Net Paid FTE Opportunity
ER	16.23	18.98	ER Visits	20,118	Worked Hours per ER Visit	1.5	1.41	0.00	-1.16	-1.16	-1.39
Emergency Response Team	5.25	5.60	Minimum Staffing	-	Worked Hours per Day	32	32.18	0.03	0.00	0.03	0.04
Infirmary	33.50	39.96	Infirmary Patient Days	37,003	Worked Hours per Infirmary Patient Day	1.5	1.52	0.48	0.00	0.48	0.58
Intake	17.12	20.18	Intake Screenings	76,712	Worked Hours per Intake Screening	0.33	0.36	1.26	0.00	1.26	1.51
Intermediate Housing	36.54	43.96	IH Detainee Days	233,800	Worked Hours per IH Detainee Day	0.259	0.27	1.53	0.00	1.53	1.83
General Population	38.23	46.02	GP Detainee Days	2,530,920	Worked Hours per GP Detainee Day	0.024	0.02	0.17	0.00	0.17	0.20
Nursing Admin	12.30	13.91	Total Detainee Days	2,764,720	Worked Hours per Detainee Day	0.006	0.01	1.90	0.00	1.90	2.27
Dental	4.62	5.80	Average # of Detainees	9,874	Detainees per Paid Dental FTEs	625	1703.73	0.00	0.00	0.00	0.00
Infection Control	1.61	2.01	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	0.05	0.03	0.00	-0.79	-0.79	-0.95
Public Health	5.06	6.34	None	None	None	None	0.00	0.00	0.00	0.00	0.00
Quality	1.76	2.01	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	0.05	0.04	0.00	-0.65	-0.65	-0.77
Pharmacy	20.26	24.42	Scripts Procesed / Day	2,300 per day	Worked Hours per Script Processed / Day	350	341	0.00	0.00	0.00	0.00
Radiology	8.60	9.91	Procedures	77,917	Worked Hours per Procedure	0.18	0.18	0.00	0.00	0.00	0.00

Functional Area	Sum of Worked FTEs	Sum of Paid FTEs	Workload Unit Measure	Workload Unit	Productivity Definition	Productivity Benchmark	Actual Productivity	Worked FTE Opportunity	Worked FTE Additions	Net Worked FTE Opportunity	Net Paid FTE Opportunity
Admin	2.33	3.62	Infirmary Patient Days	37,003	Worked Hours per Infirmary Patient Day	0.10	0.10	0.00	0.00	0.00	0.00
Admin - Access	3.63	4.26	None	-	None	0	0.00	0.00	0.00	0.00	0.00
EVS	18.07	21.13	Per 1000 Square Feet Cleaned	225	Worked Hours (annualized) per 1000 sf Cleaned	170	167.06	0.00	0.00	0.00	0.00
Finance	2.87	3.46	Facility Detainees YTD	76,712	Worked Hours per Average # of	0.06	0.06	0.00	0.00	0.00	0.00
Human Resources	0.42	1.00	Cermak Paid FTEs	403	Paid FTEs per Cermak Paid FTE	1/200	1/403	0.00	-0.84	-0.84	-1.00
IT	2.51	3.10	Infirmary Patient Days	37,003	Worked Hours per Infirmary Patient Day	0.05	0.11	1.35	0.00	1.35	1.62
Med Records	25.21	31.14	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	TBD	0.52	TBD	TBD	TBD	TBD
Supply Chain	2.70	3.10	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	0.07	0.09	0.81	0.00	0.81	0.97
Physician Providers			See Provider Analysis					2.76	0.00	2.76	3.30
JTDC Clinical	15.13	17.59	Detainee Days	126,000	Worked Hours per Detainee Day	0.18	0.19	0.91	0.00	0.91	1.09
JTDC Admiistration	4.92	6.00	Detainee Days	126,000	Worked Hours per Detainee Day	0.04	0.06	1.76	0.00	1.76	2.11
							Total	12.96	-3.43	9.53	11.41

Mental Health	32.44	39.45	Average # of Mental Health Detainees per	990	Worked Hours per Average # of Detainee per Week	2.5	1.31	0.00	-29.60	-29.60	-35.43

Mental Health worked FTEs do not include contracted services from Isaac Ray. Actual requirement must be reduced by this figure.

II. LABORATORY SERVICES

There is an estimated savings of approximately $534,000 relating to the recommendation to close the laboratory and consolidate services at Stroger.

Savings Estimate	
Description	**Cost**
Labor (7 FTEs)	$493,165
Laboratory Reagents and Supplies (16%)	$64,960
Insourcing from Reference Laboratory Services (23%	$46,000
Repairs/other	$39,500
Licensure; CAP; other misc.	$49,000
Total Estimated Savings	**$692,625**
Additional Costs	
Enhanced POCT Program	$24,360
Couriers	$50,000
Total Additional Cost	$74,360
Other misc. (7%)	$10,000
Total Estimated Additional Cost	$158,720
Estimated Net Savings	**$533,905**

III. PROVIDER PRODUCTIVITY

There is an opportunity to reduce total medical providers by 3.3 FTEs. 50% of this variance is because the number of required sessions per provider is not the national standard nine sessions a week.

Cermak Medical	FTE Required
Total Required	**29.7**
Total Paid FTE	**33.0**
Variance	**(3.3)**

Cermak currently has 2.38 FTE dentist, and 3.0 dental assistants.

- Cermak has been budgeted for 2 additional dentists and dental assistant positions, and they are actively recruiting.
- Filling these positions will place Cermak in a position to provide acute and restorative care to detainees.
- **Even filling these positions will leave Cermak short of the target of 6.5 dentists at a minimum**.

NEXT STEPS

I. LABOR PRODUCTIVITY

Nursing Services

- Assist with development, education, and implementation of management tools for nursing leadership
  - Staffing grids
  - Staffing guidelines
  - Daily productivity monitoring
  - Position control
  - Standardized nursing services quality dashboard for CCHHS hospitals
- Assist with developing a process to verify personnel expensed to cost centers each pay period are accurate
  - Develop any short term manual processes that may be necessary to track appropriately
  - Work collaboratively with leadership to identify process/methodology to utilize new upgraded Quadramed software scheduling system to develop automated management reports
- Provide nursing leadership development for hospital CNOs, Directors, and Managers as identified collaboratively with Chief Clinical Officer
  - Education sessions
  - Individual coaching/mentoring
- Assist with specific practice and/or policy issues
  - Patient sitters
  - Establishing appropriate par levels in collaboration with Materials Management

Emergency Services

- Evaluate all current throughput processes, including patient placement process and assignment of beds.
- Establish an ED nursing and physician rapid cycle team to work on ED throughput to decrease patient length of stay.
- Assist in the implementation of an ED Case Management program.

Laboratory Services

- Begin and assist in implementation of a "Core Laboratory Operational Model".
- Guide development of a Productivity Management System.
- Begin and assist in implementation of a Quality Management System (QMS).
- Develop and implement a system wide "Point of Care" Support System.
- Guide integration of Supply Chain management into the laboratory operational and capital plan process.

II. ACHN

- Operating policy/procedure enhancement
  - Communication, consistency, metrics, enforcement
- Workforce efforts
  - HR barriers, agency spend, infrastructure, fix allocation, skill mix, productivity metrics, training/competency
- Access improvement
  - Targets, metrics, corrective action
- Patient flow/throughput improvement
  - Maximize Cerner functionality, clinical recommendations, clerical recommendations, etc.
- Physician capacity/productivity tracking
  - Targets, metrics, schedules, start times, professional charges (FP/OB), etc.
- Improved efficiency
  - Expense infrastructure recommendations, reporting recommendations, Cerner superbill construction, etc.
- Data/information infrastructure/capability assessment
- Appropriate use of "Medical Home" model

III. PHYSICIAN EFFORT AND FUND PLANNING

- Requirements for Clinical Programs
- Effort for Administrative Purposes
- Sources and Uses of Funds for Research
- Sources and Uses of Funds for Teaching
- Sources and Uses of Funds for Strategic Purposes

IV. SUPPLY CHAIN

- Contract analysis, RFP processes, supplier negotiation and contract validation (including an education program on better/best practice supply negotiation strategies and industry practices in contract management).
- Implement revised organizational structure for purchasing functions at CCHHS entities.
- Provide recommendations for improvement related to the infrastructure supporting purchasing functions and materials distribution processes at JSH, OFH, PHCC, and ACHN.
- Support conversion of product and service agreements where appropriate to UHC/Novation, including analysis, department education and execution of letters of commitment/letters of participation.

- Provide information to buyers, department managers and other CCHHS designated employees on best practices in contract management and optimization of GPO services.
- Identify and implement costs savings for specific areas: Linen Contracts, Clinical Engineering, Orthopedics, Paper, Distribution agreements and other prioritized areas of improvement as designated by CCBHS Deputy Director.
- Provide monthly written status reports of updated savings.

Cook County Health and Hospitals System (CCHHS)
Performance Improvement Project

Executive Summary of Findings and Next Steps
to
Board of Directors

November 19, 2009

Agenda

- Project Scope and Approach
- Summary of Opportunity - Phase 1
- Overview of Key Findings
  - Phase 1
  - Cermak
- Next Steps

Project Scope & Approach – Physician Alignment

Physician alignment is critical to clinical resource management and supply chain management. During financial turnarounds, we would focus on areas where rapid revenue enhancement and expense reduction opportunities would be generated. These areas include:

Financial	Operational
• Physician compensation and productivity • Contracting/ compensation	• Capacity Management • Demand Management • Access Management • Flow Management

Project Scope & Approach – Workforce Efficiency

Area of Transformation	Performance Variables and Standards
Structure	» Mission and service alignment » Number of management levels by Department » Span of control targets
Resource Usage	» Comparison vs. peer "best practices" » FTEs and work hours (paid/worked) » Overtime, agency and sitters » Salary expense/rates
Human Resource Management	» Union contract requirements » Policies and procedures » Compensation structure » Outsourcing arrangements » Recruitment, retention & workforce availability » Ability to adapt to surge
Process Review	» Patient throughput and capacity management » Patient care delivery processes » Ancillary/support processes » Utilization & care management » Technology enabled process efficiencies
Productivity Systems	» Productivity tools/metrics » Resource usage against productivity standards » Strengths and weaknesses of tools
Culture and Change Management	» Constituent feedback on structure, service focus and resource utilization » Impediments, constraints and risks in force reduction » Union related processes » County requirements and processes

Project Scope & Approach – Clinical Utilization Management

- The Clinical Utilization Management assessment will help CCHHS improve clinical and operational practices and patterns while maintaining and improving, where possible, patient care.

- This initiative will require focused reviews in several areas:

Project Scope & Approach – Supply Chain

- Benchmark using NCI database for comparative hospitals
- Conduct second level of analysis using product and payment reports to identify specific pricing and utilization opportunities to develop portfolio of opportunities and savings potential

Physician Preference Items	• Orthopedic Implants • Spinal Implants • Pacemakers & Defibrillators • Stents
Purchased Services	• Agency/Temp Services • Outsourced Support Services • Biomedical Engineering • Imaging Services
Clinical Commodity Items	• Suture • Blood
Pharmacy & Laboratory Items	• Wholesaler contracting • 340b Pricing • Drug Utilization Management

Meeting Dates

Meeting Schedule

- Steering Committee #1 – July 14, 2009
- Steering Committee #2 – July 23, 2009
- Steering Committee #3 – August 6, 2009
- Steering Committee #4 – August 13, 2009
- Steering Committee #5 – August 20, 2009
- Steering Committee #6 – August 25, 2009
- Steering Committee #7 – September 30, 2009

Cermak

- Steering Committee #8 – November 3, 2009

Summary of Opportunity – CCHHS

$31.8M	**Labor Productivity**	• Achievement of NCI Identified Productivity Standards • Overtime Hours Phase I improvement
$3M	**Care Management**	• Conservative assumption of 5% improvement in all admission LOS improvement
$17-23M	**Supply Chain**	• Pricing • Utilization
$13.8M	**Physician & Mid-Level Productivity**	• Conservative estimate. Significant in depth analysis and restructuring needed before total dollar opportunity can be finalized

Total Opportunity: $65 – 72 M

Oak Forest Hospital – Productivity Summary

Oak Forest Hospital					
CATEGORY	Actual WORKED FTEs	IDENTIFIED FTE OPPORTUNITIES	FTE ADDITIONS	FTE @ NCI RECOMMENDED LEVEL	TOTAL REDUCTION %
Nursing Services	208.6	60.9	0.00	147.7	29.2%
Clinical Services	115.2	30.3	0.00	84.9	26.3%
Emergency Services	39.6	5.2	0.00	34.4	13.1%
Interventional Services	10.6	4.5	0.00	6.1	42.5%
Finance	70.2	2.3	0.00	67.9	3.3%
Support Services	264.1	92.3	0.00	171.8	34.9%
Administration	30.7	0.0	0.00	30.7	0.0%
IT/Telecom	6.9	0.0	0.00	6.9	0.0%
Clinics	0.0	0.0	0.00	0.0	0.0%
Programs and Other	0.1	0.0	0.00	0.1	0.0%
Opportunity - Worked FTEs	**746.0**	**195.5**	**0.0**	**550.5**	**26.2%**
Opportunity - Paid FTEs	**894.8**	**234.5**	**0.0**	**660.3**	
Total Opportunity - Net Paid FTEs	**894.8**	**234.5**			
Annualized Dollar Opportunity*		**$11,362,803**			

*** Average Salary & Benefits of $48,460 used to calculate Annualized Dollar Opportunity**

Provident Hospital – Productivity Summary

Provident Hospital					
CATEGORY	Actual WORKED FTEs	IDENTIFIED FTE OPPORTUNITIES	FTE ADDITIONS	FTE @ NCI RECOMMENDED LEVEL	TOTAL REDUCTION %
Nursing Services	156.2	22.8	0.00	133.5	14.6%
Clinical Services	68.9	3.0	0.00	65.9	4.3%
Emergency Services	58.0	0.0	(5.30)	63.3	-9.1%
Interventional Services	24.4	14.0	0.00	10.4	57.3%
Finance	60.1	0.0	(1.87)	62.0	-3.1%
Support Services	67.8	2.6	0.00	65.3	3.8%
Administration	22.5	0.0	0.00	22.5	0.0%
IT/Telecom	9.0	1.4	0.00	7.6	15.6%
Clinics	0.0	0.0	0.00	0.0	0.0%
Programs and Other	0.0	0.0	0.00	0.0	0.0%
Opportunity - Worked FTEs	**466.9**	**43.7**	**(7.17)**	**430.4**	**7.8%**
Opportunity - Paid FTEs	**550.4**	**51.5**	**(8.45)**	**507.4**	
Total Opportunity - Net Paid FTEs	**550.4**	**43.0**			
Annualized Dollar Opportunity*		**$2,356,259**			

*** Average Salary & Benefits of $54,775 used to calculate Annualized Dollar Opportunity**

Stroger Hospital – Productivity Summary

John H. Stroger Hospital					
CATEGORY	Actual WORKED FTEs	IDENTIFIED FTE OPPORTUNITIES	FTE ADDITIONS	FTE @ NCI RECOMMENDED LEVEL	TOTAL REDUCTION %
Nursing Services	719.3	98.6	0.0	620.7	13.7%
Clinical Services	563.6	42.3	0.0	521.4	7.5%
Emergency Services	207.3	19.5	(35.6)	223.3	-7.7%
Interventional Services	169.2	3.6	(11.9)	177.5	-4.9%
Finance	226.3	10.2	(14.1)	230.3	-1.8%
Support Services	471.1	35.2	0.0	435.9	7.5%
Administration	60.9	0.0	(1.3)	62.1	-2.1%
IT/Telecom	10.7	1.5	0.0	9.2	13.8%
Clinics	0.0	0.0	0.0	0.0	0.0%
Programs and Other	1.4	0.0	0.0	1.4	0.0%
Opportunity - Worked FTEs	**2,429.7**	**210.9**	**(62.9)**	**2,281.8**	**6.1%**
Opportunity - Paid FTEs	**2,871.8**	**249.2**	**(74.4)**	**2,697.0**	
Total Opportunity - Net Paid FTEs	**2,871.8**	**174.9**			
Annualized Dollar Opportunity*		**$14,844,442**			

*** Average Salary & Benefits of $84,894 used to calculate Annualized Dollar Opportunity**

Labor Productivity – Premium Pay

Assessment

- CCHHS hospitals are well above the NCI overtime benchmark of 2% of total worked hours.
- NCI recommends Agency Hours at the benchmark of 1% of total worked hours, but there is not a comprehensive data source to track Agency hours, so the opportunity was unable to be assessed.

Entity	Indicator	2009 YTD	2008	NCI Preferred %	Phase I Reduction Target (decrease 2%)	Paid FTEs Converted from Premium	$ Savings at Phase I Target
Oak Forest	Overtime Hours as % of Worked Hours	4.47%	4.99%	2.00%	2.47%	8.0	$193,000
Provident		10.81%	11.46%	2.00%	8.81%	11.1	$303,000
Stroger		8.77%	9.09%	2.00%	6.77%	64.6	$2,743,000
	TOTAL PHASE I REDUCTION SAVINGS						$3,239,000

Recommendation

- Overtime
  - In Phase I, reduce overtime by 2 points and continue to drive down further as hiring and staffing practices improve.
- Agency
  - Track hours alongside regular worked and overtime hours in the timekeeping system

Overview of Key Findings - Phase 1

NAVIGANT CONSULTING

Physician Services – Providers

NCI employs a mission-based management methodology with the acronym “CARTS” to analyze the multifaceted activity of an academic or teaching physician.

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Physician Services – Providers

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- It is important to note that the clinical requirement has already been enhanced by 30% to account for inferior data quality.

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The recommendation is to eliminate 85% of excess provider positions, or 90 FTEs, after all mission requirements have been satisfied.

Physician Services – Providers

Additional comments and recommendations include:

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- **It is paramount that this be fixed.**

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- Physicians self-report 48.5% of their time as “teaching”, much greater than the need.
- Clinical activity is a much smaller expectation than required.

Resolve Human Resource issues to align with expectations.

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- Create ability to split 1.0 FTE positions into smaller increments.

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Establish definitive functional skill set and adjust staffing mix accordingly.

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Metric	Current Level	Low Target	High Target
Supply Expense % of Net Operating Expense	36.9%	22.4%	16.6%
Supply Expense % Net Revenue	63.3%	43.5%	34.3%
Supply Expense Per Adj Discharge	111.0%	81.6%	66.2%
Target Peer Group Ranking (percentile)	70.4%	49.2%	39.1%
Corresponding Savings		$ 17,316,081	$ 23,500,396

Source: NCI Supply Chain Normalization based upon data from CCHHS Corporate for fiscal year 2008

Supply Chain

During the engagement, specific opportunities in the range of $11M - $15M were identified. Examples of these opportunities include:

CATEGORY	INITIATIVE	ANNUAL SPEND	LOW TARGET SAVINGS	HIGH TARGET SAVINGS
Pharmacy	Drug Utilization - Outpatient Formulary		$ 1,063,234	$ 1,500,000
	Drug purchase under 340B		$ 210,000	$ 1,000,000
	Revenue from Copay		$ 500,000	$ 1,000,000
Pharmacy Total			**$ 1,773,234**	**$ 3,500,000**
Lab	Insourcing of lab tests	$ 805,247	$ 219,523	$ 219,523
	Reference Lab pricing	$ 805,233	$ 184,256	$ 184,256
	Blood Bank	$ 3,200,000	$ 39,409	$ 78,755
Lab Total		**$ 4,810,480**	**$ 443,188**	**$ 482,534**
Non-Clinical	Biomedical Contracts	$ 6,445,428	$ 1,300,000	$ 1,700,000
	Contract Security	$ 984,911	$ 276,804	$ 511,293
	Medical Gases	$ 1,900,000	$ 133,888	$ 169,888
	Dietary Savings	$ 1,561,964	$ 121,429	$ 265,402
Non-Clinical Total		**$ 10,892,303**	**$ 1,832,121**	**$ 2,646,583**
Sub Total		**$ 28,472,752**	**$ 5,585,989**	**$ 8,952,119**

Note 1: Drug purchases billed under the 340B program has been extended to Oak Forest ER department
2: Drug formulary and utilization changes identified during the review has been initiated at CCHHS for specific drugs

Clinical Resource Management

Key findings and recommendations include:

The current model for each of the facilities would be described as **a traditional Utilization Review and Discharge Planning approach** to case management.
Compliance/preventative measures, such as Medicare conditions for participation Recovery Audit Contractors focus areas, are limited.
Limited data available and no case management dashboard/report card exists to evaluate the impact of case management activities.
Develop written criteria to guide patient assignments based on changes in the patient condition that are consistent across similar levels-of-care.
Develop a CCHHS Nursing Services Quality Dashboard monitoring standardized key nursing sensitive metrics.

Clinical Resource Management

Additional resources are required to achieve effective staffing and impact average length of stay (ALOS) at each hospital.

Staffing	Payroll Spend 7/28/09	Proposed Paid FTEs	Net FTE Impact	Investment Dollars
PHASE I				
Stroger			1.0	
Oak Forest	10	7.2	(2.8)	
Provident	6	8.2	2.2	
Sub-Total Phase 1				**($30K)**
PHASE II				
Stroger			15.7	
Oak Forest	N/A	N/A		$0
Provident	N/A	N/A		$0
Sub-Total Phase 2				**$947K**
PHASE III				**TBD**
TOTAL				**$917K**

Clinical Resource Management

The additional expenditure of resources would be more than compensated by a favorable return on investment (ROI) in average length of stay.

Case Management All Hospitals

Staffing	Current All Payor ALOS	5% Improvement Opportunity	Total Day Opportunity	Financial Impact
Stroger	5.04	4.79	5908	$2.6M
Oak Forest	6.1	5.8	939	$0.4M
Provident	3.98	3.98	0	
TOTAL				**$3.0M**
ROI				**3 to 1**

Actual opportunity is likely much greater. At present, it is not possible to track unnecessary admissions, inaccurate coding of diagnosis, and other critical variables.

Notes:
- Current ALOS data source = Cook County Health & Hospitals System, December '08- March '09
- A conservative estimated 5% opportunity based upon Navigant's experience in like facilities
- FTE salary dollar value estimated at $60,000 per year
- Opportunity day value estimated at $450/day

Overview of Key Findings - Cermak

NAVIGANT CONSULTING

Cermak

I. LABOR EFFECTIVENESS

There are modest opportunities for improvement in labor effectiveness in a number of departments at Cermak. These are offset by a need to add additional personnel in Mental Health.

Functional Area	Sum of Worked FTEs	Sum of Paid FTEs	Workload Unit Measure	Workload Unit	Productivity Definition	Productivity Benchmark	Actual Productivity	Worked FTE Opportunity	Worked FTE Additions	Net Worked FTE Opportunity	Net Paid FTE Opportunity
ER	**16.23**	**18.98**	ER Visits	20,118	Worked Hours per ER Visit	1.5	1.41	**0.00**	**-1.16**	**-1.16**	**-1.39**
Emergency Response Team	**5.25**	**5.60**	Minimum Staffing	-	Worked Hours per Day	32	32.18	**0.03**	**0.00**	**0.03**	**0.04**
Infirmary	**33.50**	**39.96**	Infirmary Patient Days	37,003	Worked Hours per Infirmary Patient Day	1.5	1.52	**0.48**	**0.00**	**0.48**	**0.58**
Intake	**17.12**	**20.18**	Intake Screenings	76,712	Worked Hours per Intake Screening	0.33	0.36	**1.26**	**0.00**	**1.26**	**1.51**
Intermediate Housing	**36.54**	**43.96**	IH Detainee Days	233,800	Worked Hours per IH Detainee Day	0.259	0.27	**1.53**	**0.00**	**1.53**	**1.83**
General Population	**38.23**	**46.02**	GP Detainee Days	2,530,920	Worked Hours per GP Detainee Day	0.024	0.02	**0.17**	**0.00**	**0.17**	**0.20**
Nursing Admin	**12.30**	**13.91**	Total Detainee Days	2,764,720	Worked Hours per Detainee Day	0.006	0.01	**1.90**	**0.00**	**1.90**	**2.27**
Dental	**4.62**	**5.80**	Average # of Detainees	9,874	Detainees per Paid Dental FTEs	625	1703.73	**0.00**	**0.00**	**0.00**	**0.00**
Infection Control	**1.61**	**2.01**	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	0.05	0.03	**0.00**	**-0.79**	**-0.79**	**-0.95**
Public Health	**5.06**	**6.34**	None	None	None	None	0.00	**0.00**	**0.00**	**0.00**	**0.00**
Quality	**1.76**	**2.01**	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	0.05	0.04	**0.00**	**-0.65**	**-0.65**	**-0.77**
Pharmacy	**20.26**	**24.42**	Scripts Procesed / Day	2,300 per day	Worked Hours per Script Processed / Day	350	341	**0.00**	**0.00**	**0.00**	**0.00**
Radiology	**8.60**	**9.91**	Procedures	77,917	Worked Hours per Procedure	0.18	0.18	**0.00**	**0.00**	**0.00**	**0.00**

Cermak

Functional Area	Sum of Worked FTEs	Sum of Paid FTEs	Workload Unit Measure	Workload Unit	Productivity Definition	Productivity Benchmark	Actual Productivity	Worked FTE Opportunity	Worked FTE Additions	Net Worked FTE Opportunity	Net Paid FTE Opportunity
Admin	**2.33**	**3.62**	Infirmary Patient Days	37,003	Worked Hours per Infirmary Patient Day	0.10	0.10	**0.00**	**0.00**	**0.00**	**0.00**
Admin - Access	**3.63**	**4.26**	None	-	None	0	0.00	**0.00**	**0.00**	**0.00**	**0.00**
EVS	**18.07**	**21.13**	Per 1000 Square Feet Cleaned	225	Worked Hours (annualized) per 1000 sf Cleaned	170	167.06	**0.00**	**0.00**	**0.00**	**0.00**
Finance	**2.87**	**3.46**	Facility Detainees YTD	76,712	Worked Hours per Average # of	0.06	0.06	**0.00**	**0.00**	**0.00**	**0.00**
Human Resources	**0.42**	**1.00**	Cermak Paid FTEs	403	Paid FTEs per Cermak Paid FTE	1/200	1/403	**0.00**	**-0.84**	**-0.84**	**-1.00**
IT	**2.51**	**3.10**	Infirmary Patient Days	37,003	Worked Hours per Infirmary Patient Day	0.05	0.11	**1.35**	**0.00**	**1.35**	**1.62**
Med Records	**25.21**	**31.14**	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	TBD	0.52	**TBD**	**TBD**	**TBD**	**TBD**
Supply Chain	**2.70**	**3.10**	Facility Detainees YTD	76,712	Worked Hours per Facility Detainee YTD	0.07	0.09	**0.81**	**0.00**	**0.81**	**0.97**
Physician Providers			See Provider Analysis					**2.76**	**0.00**	**2.76**	**3.30**
JTDC Clinical	**15.13**	17.59	Detainee Days	126,000	Worked Hours per Detainee Day	0.18	0.19	**0.91**	**0.00**	**0.91**	**1.09**
JTDC Admiistration	**4.92**	6.00	Detainee Days	126,000	Worked Hours per Detainee Day	0.04	0.06	**1.76**	**0.00**	**1.76**	**2.11**
							Total	**12.96**	**-3.43**	**9.53**	**11.41**

Mental Health	**32.44**	**39.45**	Average # of Mental Health Detainees per	990	Worked Hours per Average # of Detainee per Week	2.5	1.31	**0.00**	**-29.60**	**-29.60**	**-35.43**

Mental Health worked FTEs do not include contracted services from Isaac Ray. Actual requirement must be reduced by this figure.

II. LABORATORY SERVICES

There is an estimated savings of approximately $534,000 relating to the recommendation to close the laboratory and consolidate services at Stroger

Savings Estimate	
Description	**Cost**
Labor (7 FTEs)	$493,165
Laboratory Reagents and Supplies (16%)	$64,960
Insourcing from Reference Laboratory Services (23%)	$46,000
Repairs/other	$39,500
Licensure; CAP; other misc.	$49,000
Total Estimated Savings	**$692,625**
Additional Costs	
Enhanced POCT Program	$24,360
Couriers	$50,000
Total Additional Cost	$74,360
Other misc. (7%)	$10,000
Total Estimated Additional Cost	$158,720
Estimated Net Savings	**$533,905**

Cermak

III. PROVIDER PRODUCTIVITY

There is an opportunity to reduce total medical providers by 3.3 FTEs. 50% of this variance is because the number of required sessions per provider is not the national standard nine sessions a week.

Cermak Medical	FTE Required
Total Required	29.7
Total Paid FTE	33.0
Variance	(3.3)

Cermak currently has 2.38 FTE dentist, and 3.0 dental assistants.

- Cermak has been budgeted for 2 additional dentists and dental assistant positions, and they are actively recruiting.
- Filling these positions will place Cermak in a position to provide acute and restorative care to detainees.
- **Even filling these positions will leave Cermak short of the target of 6.5 dentists at a minimum**.

Next Steps

NAVIGANT CONSULTING

Next Steps – Labor Effectiveness

Key areas:

- Nursing Services
- Emergency Services
- Laboratory Services

Sustainable results require:

- **Infrastructure & Tools**
- **Training/education**
- **Cultural shift**

Next Steps – ACHN

- Operating Policy / Procedure enhancement
  - Communication, consistency, metrics, enforcement
- **Workforce efforts**
  - HR barriers, agency spend, infrastructure, fix allocation, skill mix, productivity metrics, training / competency
- Access improvement
  - Targets, metrics, corrective action
- **Patient Flow / Throughput improvement**
  - Maximize Cerner functionality, clinical recommendations, clerical recommendations, etc.
- **Physician Capacity / Productivity tracking**
  - Targets, metrics, schedules, start times, professional charges (FP/OB), etc.
- Improved efficiency
  - Expense infrastructure recommendations, reporting recommendations, Cerner superbill construction, etc.
- Data / Information Infrastructure / Capability assessment
- Appropriate use of “Medical Home” model

Next Steps – Physician Effort and Funds Planning

- Requirements for Clinical Programs
- Effort for Administrative Purposes
- Sources and Uses of Funds for Research
- Sources and Uses of Funds for Teaching
- Sources and Uses of Funds for Strategic Purposes

Need to reset physician work expectations

Next Steps – Supply Chain

- **Contract analysis, RFP processes, supplier negotiation and contract validation** (including an education program on better/best practice supply negotiation strategies and industry practices in contract management).
- **Implement revised organizational structure for purchasing functions at CCHHS entities.**
- Provide recommendations for improvement related to the infrastructure supporting purchasing functions and materials distribution processes at JSH, OFH, PHCC, and ACHN.
- **Support conversion of product and service agreements where appropriate** to UHC/Novation, including analysis, department education and execution of letters of commitment/letters of participation.
- **Provide information to buyers, department managers and other CCHHS** designated employees on best practices in contract management and optimization of GPO services.
- **Identify and implement costs savings for specific areas**: Linen Contracts, Clinical Engineering, Orthopedics, Paper, Distribution agreements and other prioritized areas of improvement as designated by CCBHS Deputy Director.
- Provide monthly written status reports of updated savings.

Summary of Opportunity – CCHHS

$31.8M	**Labor Productivity**	• Achievement of NCI Identified Productivity Standards • Overtime Hours Phase I improvement
$3M	**Care Management**	• Conservative assumption of 5% improvement in all admission LOS improvement
$17-23M	**Supply Chain**	• Pricing • Utilization
$13.8M	**Physician & Mid-Level Productivity**	• Conservative estimate. Significant in depth analysis and restructuring needed before total dollar opportunity can be finalized

Total Opportunity: $65 – 72 M